Medicaid Information Bulletin

April 2004

Web address: http://health.utah.gov/medicaid

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538-6155 or toll free 1-800-662-9651

BULLETINS BY TYPE OF SERVICE

On-Line (Internet) Address for Medicaid:

http://health.utah.gov/medicaid

Please make sure that any Medicaid bookmarks that you have are the new Medicaid Internet address shown above. The old web site is not being kept up to date, and it will be discontinued in late 2004. The old Medicaid Internet address was printed in many Medicaid documents. The old address will be corrected as each document is updated. We apologize for any frustration or confusion this change in address may cause.

World Wide Web: http://health.utah.gov/medicaid (Formerly http://www.health.state.ut.us/medicaid)

Medicaid Information

- Salt Lake City area, call 538-6155.
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.
- From other states, call 1-801-538-6155.

Requesting a Medicaid publication?

Send a Publication Request Form.

- by FAX: 1-801-536-0476
- by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106

04 - 35 Hyperbaric Oxygen Therapy

Hyperbaric Oxygen Therapy (HBO) is a medical treatment used to help resolve certain medical problems. In certain circumstances, it represents the primary treatment modality while in others it is an adjunct to surgical or pharmacologic interventions. HBO therapy places the patient in an enclosed pressure chamber breathing 100% oxygen at greater than one atmospheric pressure.

Beginning June 1, 2004, the following changes are made in the Medicaid HBO therapy policy:

- Prior authorization is required on CPT Code 99183 and ICD.9.CM Code 9395.
- Therapy may be provided as an outpatient service, but only in a hospital based facility.
- Therapy must be administered only in an enclosed full body pressure chamber.
- Conditions approved for coverage are listed in Medicaid Procedure Criteria #21 and follows closely the Medicare approved criteria.
- Constant monitoring and immediate availability of the physician is essential for all procedures. This is a professional activity that cannot be delegated because it requires independent medical judgement by the physician.

Diabetic wounds of the lower extremities in patients who meet specific criteria have now been added to the criteria. This therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy. HBO therapy must be used in addition to standard wound care.

Medicaid Medical and Surgical Procedures Criteria #21 has been updated and is available to be added to the physician and hospital manual. ☐

04 - 36 Attention: Mental Health Centers, Substance Abuse Treatment Providers and DHS Contracted Mental Health Providers

Changes have been made to the Utah Medicaid Provider Manual for Mental Health Centers, the Utah Medicaid Provider Manual for Substance Abuse Treatment Services, and the Utah Medicaid Provider Manual for Diagnostic and Rehabilitative Mental Health Services by DHS Contractors.

Changes include clarification of individuals who may render services, including the assessment by a non-mental health therapist, and revision of the definition of individual skills training and development and psychosocial rehabilitative services.

Providers will find attached an updated Section Two of their respective provider manuals.
A vertical line in the margin is next to the text that has been changed.

Contact Karen Ford at 538-6637 or kford@utah.gov if you have questions. ☐

04 - 37 Attention: Targeted Case Management for the Chronically Mentally Ill Providers (Mental Health Centers), Targeted Case Management for Substance Abuse (Substance Abuse Treatment Providers) and Targeted Case Management for the Homeless Providers

The description of covered services/activities has been modified to clarify that coordinating the client's medications/medication regimen with other providers, monitoring the client's symptomatology and functioning, medications and medication regimen are covered targeted case management activities.

Mental Health Centers will find attached an updated page 4, substance abuse treatment providers will find attached an

updated page 28, and targeted case management for the homeless providers will find attached an updated page 5. A vertical line in the margin is next to the text that has been changed. Please replace the current page with this updated page.

Contact Karen Ford at 538-6637 or kford@utah.gov if you have questions. ☐

04 - 38 CPT lists updated for Medicaid

Non-covered

61863 Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (i.e. thalmus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) without use of intraoperative microelectrode recording; first array
61864 Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (i.e. thalmus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) without use of intraoperative microelectrode recording; each additional
61867 Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (i.e. thalmus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) with use of intraoperative microelectrode recording; first array
61868 Twist drill, burr hole, craniotomy or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (i.e. thalmus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray) with use of intraoperative microelectrode recording; each additional
65780 Ocular surface reconstruction, amniotic membrane transplantation
85396 Coagulation/fibrinolysis assay, whole blood (i.e. viscoelastic clot assessment) including use of any pharmacologic additive(s) as indicated, including interpretation and report per day
88361 Morphometric analysis; tumor immunohistochemistry (i.e. her-2neu, estrogen receptor/progesterone resceptor) qualitative or semiquanitative

Covered

35697 Reimplantation visceral artery to infrarenal aortic prosthesis each artery Note: CPT 2003 guidelines state code 33877 is mutually exclusive to code 35697.
63103 Vertebral corpectomy (vertebral body resection) partial or complete, lateral extracavity approach with decompression of spinal cord and/or nerve root(s) (i.e. tumor or retropulsed bone fragments), thoracic or lumbar, each additional
87329 Infectious antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method, giardia
87269 Infectious antigen detection by immunofluorescent technique, giardia Note: The code 87269 will be denied as mutually exclusive when submitted with code 87329.
88112 Cytopathology, selective cellular enhancement technique with interpretation (i.e. liquid based slide preparation method), except cervical and vaginal. (Note: CPT2004 guidelines state do not report code 88112 with code 88108, mutually exclusive)

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04 - 39 Occupational Therapy in Home Health

Occupational Therapy through home health is not a covered service except under the CHEC program for children. Requests for service must be made through the Utilization Management nurse reviewers with subsequent review by the CHEC Committee for a determination of coverage. Information for review must be based on physician orders, a plan of care, and clear indication of medical necessity. Occupational therapy in the home is not an option for convenience of physician, family or therapist. If the child is able to leave the home for school, medical appointments, or any other activities, therapy in an outpatient setting must be the first consideration for coverage. In order to adequately review requests in a timely manner, complete, detailed information should accompany the request.

Information to be provided for review includes, but is not limited to:

- A plan of care based on physician order
- Diagnosis and associated medical problems.

- Goals of therapy clearly stated. There must be an expectation that with treatment the patient's medical condition will improve in a predictable period of time.

- If requesting recertification, documentation must clearly show child has met previous goals, made measurable improvement and is moving on and progressing to new goals. Continued service is questionable if there is no progress.
  Goals must include teaching family care givers to work with the child on a daily basis so that improvements can be maintained.

- What medical problems does the child have that would support or justify home bound status? Explain.

- If immunosuppression is mentioned, why is the child immunosuppressed? What documentation is available to support such a finding? (Certain lab tests define immunosuppression. Patients vary in their susceptibility to infections, depending on the severity and duration of immunosuppression.)

- General or ambiguous statements should be avoided.
  "Provider 'feels' community interaction would be a compromise to health." Why?
  "Frequent illness" Why? What is the cause or concern?

- If the child is on the Tech Dependent Waiver or Early Intervention Programs, the information MUST be included with each request.

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04 - 40 Psychiatric Evaluation Policy and Code Reminder

A psychiatric evaluation provided by a board Certified Psychiatrist is required for patients who are seeking prior authorization for selected surgical procedures. These procedures may require significant life style changes and/or compliance with rigorous treatment and followup regimens. This evaluation must include an assessment of the patient's ability to understand the procedure being requested. It also must determine if the patient is psychologically stable and capable of compliance. Guidelines established by HCFA (now CMS) and the American Psychiatric Association must be followed in achieving this evaluation. These guidelines are found in the Physician Manual.

As a reminder, the following policy applies:

- Patients seeking selected surgical procedures will be referred to a psychiatric consultant through the Utah Department of Health, Division of Health Care Financing, Utilization Review Committee.

- CPT Consultation code 99245 is established as the appropriate code to report and bill for the Psychiatric Evaluation for patients seeking selected surgical procedures.

- The Evaluation and Management elements of this code are:
  Comprehensive History,
  Comprehensive Examination, and
  Medical decision making of high complexity.
  Typically, 80 minutes are spent with the patient or family.

- A written report to the requesting physician or other appropriate source is included as part of the service defined by CPT code 99245 and the associated payment.

- A CMS 1500 claim form must be submitted to Health Care Financing using CPT code 99245. Pricing is established in the Reference File. Additional payment may be warranted. A 22 modifier can be added to the code (99245-22). Physician review will be initiated, and a determination will be made about adding an additional amount of money to the claim for this specialty care. ☐

04 - 41 Laboratory Services: CLIA Requirement

See the following updated list of CLIA codes and new manufacturers. Not all the codes listed are covered by Medicaid. ☐

04 - 42 Home Health Nursing Visit Code Revised

Effective October 1, 2003, HIPAA codes were established to replace the "Y" codes previously used for home health services. Changes have been made in the new codes as follows:

> Code GO154 will be maintained to identify skilled nursing services which can only be provided by a registered nurse in the home. The service definition remains the same. Limit definitions have changed. The original payment will be restored.
>
> Code T1003 minor changes have been made to clarify limit changes on BID services.

Section 2, Chapter 6, Home Health Procedure Codes, has been updated in the appropriate sections to reflect these changes. ☐

04 - 43 Drug Limits and Criteria

The DUR Board has set a cumulative limit of 30 units/30 days for sedative-hypnotics effective 4/1/04. These include: Sonata, Halcion, Ambien, Prosom, Doral, Restoril and their generic equivalents.

The DUR Board has set a a cumulative limit of 30units/30 days for Detrol LA and their generic LA equivalents effective 4/1/04.

The DUR Board has placed Ditropan XL and Oxytrol and their generic equivalents on prior approval effective 4/1/04. Criteria requires documented failure on oral generic short acting oxybutynin chloride.

The DUR Board has placed a prior approval on Olux (clobetasol propionate) foam and generic equivalents effective 4/1/04. Criteria requires documented failure on generic clobetasol propionates creams or ointments within the last 12 months.

The DUR Board has placed a prior approval on Luxiq (betamethasone valerate) foam and generic equivalents effective 4/1/04. Criteria requires documented failure on generic betamethasone valerate creams or ointments within the last 12 months. ☐

04 - 44 Audiology-Newborn Screening

Auditory screening for newborn babies as mandated by Utah S. B. 40 will be reimbursed by the following means:

a. If the hospital performing the newborn delivery is a DRG hospital, the auditory screening is included in the DRG and the audiologist is reimbursed by the hospital from the DRG funds paid by Medicaid.

b. If the hospital performing the newborn delivery is a non-DRG hospital or the delivery occurs in a non-hospital setting, the audiologists may bill Medicaid for the auditory screening.

c. If the screening does not take place at birth and the infant is screened at a subsequent date, the audiologists can bill Medicaid for the auditory screening.

For reimbursement under “b” and “c” above, use code V5008, Hearing screening (infant) otoacoustic test. Do not bill using CPT codes for newborn screening up to one year of age.

Audiology-Ear Molds

Ear molds, code V5275, are included in the global fee paid for hearing aids and may not be billed separately. Only if the ear mold is not made in conjunction with a hearing aid (new or replacement) should a provider bill for the ear mold. ☐

04 - 45 HIPAA Transaction Update

Effective April 1, 2004 Utah Medicaid supports all HIPAA transactions with the exception of the 278 (prior authorization). Prior to submission of HIPAA compliant transactions, it will be necessary to obtain a new trading partner number from Utah Health Information Network (UHIN). Visit the UHIN website at www.uhin.com for more information. Once a trading partner number is obtained, a request for a Medicaid EDI account must be submitted. The application is available http://www.health.utah.gov/hipaa/enroll.htm

Providers are encouraged to use the HIPAA compliant formats. Medicaid services such as Medicaid On-Line and the Medicaid Bulletin Board will be supported temporarily due to Medicaid's contingency plan, however providers should transition over to the HIPAA transactions. ☐

04 - 46 Pregnant Smokers put Babies at Asthma Risk

Mothers who smoke during pregnancy greatly increase their children's risk of developing asthma in the first seven years of life, according to an American Journal of Public Health (AJPH) study of more than 60,000 births. (AJPH, January, 2004)

Researchers focused on about 59,000 births in Finland from 1987 – 1994 and followed the children for seven years. The risk of developing asthma during a child's first seven years was 25 percent higher if the mother smoked less than 10 cigarettes a day during pregnancy and 36 percent higher if the mother smoked more than 10 cigarettes a day during pregnancy when compared with non-smoking mothers.

Among those whose mothers smoked during pregnancy, the average birth weight was 250 grams lower than babies born to non-smoking mothers, and babies born to smoking mothers were three times as likely to be small for gestational age. (The Nation's Health, February 2004, page 10)

Utah Medicaid covers tobacco cessation for pregnant women. Zyban and nicotine replacement therapy may be provided. Self help booklets are available, as well as, Quit Line services, individual and group counseling through the following local health departments:

Bear River	435-792-6513	Southwest	435-986-2563
Central	435-896-5451	Tooele	435-843-2300
Davis	801-451-3340	TriCounty	435-781-5475
Salt Lake	801-468-2697	Utah	801-370-8798
Southeast	435-637-3671	Weber Morgan	801-399-8104

Medicaid Contact: Marilyn Haynes-Brokopp
801.538.6206
mbrokopp@utah.gov ☐

Separate Bulletins Issued for Non-Traditional Medicaid Plan and Primary Care Network

The Division of Health Care Financing issues separate bulletins to inform providers of changes in the Non-Traditional Medicaid Plan and the Primary Care Network Program. The bulletins are mailed only to enrolled providers who are affected by information in the bulletins.
The April 2004 NTM bulletin will be issued for the following types of services: Optometrists, Ophthalmologists, and, Physician.
The April 2004 PCN bulletin will be issued for the following types of services: Optometrists, Pharmacy, Physician [Physician includes Ophthalmologists] and Hospital.
All bulletins are available on the Medicaid Provider's web site: http://health.utah.gov/medicaid/provhtml/provider.html
Bulletins are under the headings Medicaid Information Bulletins, Non-Traditional Medicaid Plan, and Primary Care Plan.
Contact Medicaid Information if you want a printed NTM or PCN bulletin that is not included with this Medicaid bulletin.

04 - 47 Reporting Third Party Payments (TPL) - Paper Claims Only

Due to provider input and review of the Insurance Payment Report (IPR) form, Medicaid will no longer require usage of the form to report third party payment. Providers are required to report third party liability (TPL) on the appropriate claim form for all Medicaid and Medicare/Medicaid Coordination of Benefit (COB) claims.

For Medicaid claims, TPL information must be reported in the positions listed below. An Explanation of Benefits (EOB) from the primary payer must be attached to the claim when payment from the TPL is "0", or a crossover claim is submitted past the timely filing requirement of 6 months. For Healthy U or Molina TPL claims, contact the health plan for specific billing instructions.

Effective 7/1/04, claims will be returned to the provider if the claim is submitted with an EOB and no TPL information is entered on the claim form.

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CMS-1500 (HCFA-1500) See Medicare/Medicaid COB instructions listed below	
Box	Instructions
28	Total Claim Charge
29	Amount Paid by other payer. Do not include contractual obligation (write off).
30	Balance Due. Report patient responsibility and contractual obligation.

UB92	
Form Locator	Instructions
54 A,B,C	Prior Payments made by other insurance carrier. Contractual adjustments should not be reported. The contractual amount will be calculated by Medicaid (Total charge - Prior Payments - Patient Estimated Amount Due = Contractual Adjustment).
55 P	Patient Estimated Amount Due or Patient Responsibility as listed by other insurance carrier.

1994	**1999**	**DENTAL**
Box		Instructions
42	59	Payment by other plan. Contractual adjustments should not be reported. The contractual amount will be calculated by Medicaid (Total charge - Payment by other plan - Patient pays = Contractual Adjustment).
42	59	Patient pays. Amount as listed by other insurance carrier as patient responsibility.
2002 Form - Medicaid recommends providers do not use this form. There are no fields to report payment by other plan or patient responsibility.		

Medicare/Medicaid Crossover: CMS-1500 paper claims require line level reporting of TPL. The information must be submitted in the boxes listed below. Claims submitted for regular Medicaid may also utilize this format rather than the format listed above (excluding directions for box 1). Medicaid will calculate patient responsibility and contractual obligation from the information submitted. When submitting Medicare/Medicaid Crossover Institutional paper claims, follow the instructions above.

CROSSOVER CMS-1500 (HCFA-1500)		
Box	**Instructions**	
1	Check both the Medicare and Medicaid boxes.	
24J	Reason code for coordination of benefits (COB). Use ANSI 837 Standard Claim Adjustment Reason Codes. Reason codes should be present on the explanation of benefit received from the primary carrier. If not available, leave blank.	
24K	COB amounts. For each line of service, the box must contain two lines of information: Indicator of "T" and amount paid by the other payer. Indicator of "C" and contractual obligation (write-off) amount.	Example: T - 23.00 C - 17.00
28	Total Claim Charge	
29	Amount Paid. Report the total of the TPL and contractual obligation from the other payer. Amount must equal total of all values reported in 24K.	
30	Balance Due. Report the patient responsibility.	

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04 - 48 Medical Supplies–DME Rental

Rental of DME: Certain highly specialized equipment is so technical and costly to maintain that it is fiscally more responsible to furnish the equipment to a client on a permanent rental basis. This rental will include maintenance and back-up equipment if needed. This type of rental DME will have an RR modifier associated with the code

Other rental DME may be capped and no more rentals paid after 12 months. These codes will have the modifier LL associated with the code. DME that is capped and require maintenance and service may use the "ms" modifier once every six months, beginning six months after the rental has converted to a purchase and all rental charges have been billed for reimbursement for maintenance and service required to maintain the device. This may be billed using the HCPCs code and adding the "ms" modifier on the HCFA 1500 form. The reimbursement for the "ms" modifier will be equal to one monthly rental fee. A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use ceases in order for a new 12-month rental period to begin.

The maintenance and service fee is for maintenance and service on the DME as needed to keep the equipment operating properly and includes all supplies, service and maintenance which are routinely supplied when the item was being provided as a monthly rental.

New codes

Y 6133, Gel positioning cushion is replaced with **K0656**, Skin Protection Wheelchair seat Cushion, less than 22 inches, any depth (gel cushion) and **K0657**, Skin Protection Wheelchair seat Cushion, 22 inches or greater, any depth (gel cushion)
Y 6135, Wheelchair GS back Jay is replaced with **K0662**, Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, includes mounting hardware (Jay back) and
K0663, Positioning wheelchair back cushion, posterior, width greater than 22 inches, any height, includes mounting hardware (Jay back)
These new codes have the same pricing as the Y-codes being replaced.

S1015, IV tubing extension set, is closed effective April 1, 2004 with no replacement, this will be included as part of the

global fees for S5520 and S5521. ☐